(15)

No. 88-1377

In the Supreme Court of the United States

OCTOBER TERM, 1989

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

BRIAN ZEBLEY, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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This case presents a single legal issue: whether the regulation requiring a claimant seeking SSI child's disability benefits to establish that he has an impairment that meets or equals the severity of a listed impairment (20 C.F.R. 416.924) exceeds the statutory authority of the Secretary of Health and Human Services and therefore is invalid on its face.

Respondents argue that the regulation conflicts with 42 U.S.C. 1382c(a)(3), which provides that a child is disabled if he has an impairment of "comparable severity" to one that would render an adult unable to engage in any substantial gainful activity. Indeed, according to respondents, Section 1382(a)(3) affirmatively requires the Secretary to follow a much different approach, namely: (1) to assess the "residual functional capacity" (RFC) of every child whose impairment does not meet or equal an impairment in Part A or Part B of the Listing of Impairments, and (2) to consider the child's RFC, together with unspecified non-medical factors (similar to the non-medical factors of age, education and work experience for an adult) to determine whether the child is disabled for purposes of Title XVI. Respondents' contention (Br. 15) that the Act "plainly" requires the evaluative approach they prefer is refuted by the rele-

vant statutory text. Section 1382c(a)(3)(A) makes no mention of the "residual functional capacity" of children, and Section 1382(a)(3)(B) makes no mention of any non-medical factors that must be considered for children—a significant omission in light of its express requirement that the non-medical factors of age, education and work experience be considered for adults.

By contrast, we have shown in our opening brief that the requirement that a claimant's impairment meet or equal the Listing is supported by the text, legislative history, and purposes of Section 1382c(a)(3)(A) (Gov't Br. 23-30, 37-41) and by Section 501(b) of the Unemployment Compensation Amendments of 1976 (90 Stat. 2685), which directed the Secretary to publish "criteria" to be employed "to determine disability" in children under age 18. Gov't Br. 24, 30-34. We also have shown that the Listing requirement has been an essential part of the child's disability program since its inception in January 1974, and that it incorporates functional considerations by identifying impairments that have an impact on development and growth in children that is comparable to the effect of impairments that prevent an adult from working. Gov't Br. 31-32, 36-40.

Respondents and their amici have failed to carry their heavy burden of overcoming this extensive support for the central regulatory requirement that has governed the adjudication of more than one million claims for child's disability benefits since the outset of the SSI program in 1974. Indeed, their submissions largely ignore the statutory support for the regulatory requirement and instead are devoted primarily to criticizing various aspects of the Listing itself or the way in which it is has been applied to particular diseases or even to particular claimants. Those matters are beyond the scope of this suit, which was brought as a facial challenge to the Listing requirement.

A. Before addressing respondents' more specific legal arguments, we shall seek to correct several basic errors in respondents' brief about the operation of the disability programs for both children and adults. Respondents argue (Br. 15-24) that Part A and Part B of the Listing are divorced from "functional" considerations and prevent an "individualized" assessment of each claimant's condition, and they assume that their RFC approach could be substituted for the Listing approach with little disruption. Respondents are wrong in every respect.

1. The whole point of the Listing is to identify those impairments whose functional impacts are sufficiently severe to render a claimant disabled based on the presence of the impairment alone. Part B of the Listing, which sets forth additional children's impairments, is patterned after Part A, which is applied at step three of the sequential evaluation process for adults. See Gov't Br. 4-7. Part A is subdivided into categories of impairments affecting each principal body system (*e.g.*, musculoskeletal, respiratory, cardiovascular, mental, neurological), and it identifies the "criteria" for each listed impairment (*i.e.*, the medical signs, symptoms, and findings) that demonstrate the existence of an impairment of sufficient severity to deem the claimant to be disabled, without the need to consider his "vocational" factors of age, education, and work experience. 20 C.F.R. 416.925(a). Although the criteria are stated largely in medical terms, the requisite level of severity for each impairment was established on the basis of its functional consequences—its effect on the claimant's ability to perform work-related activities. Impairments are included in the Listing on the basis of the Secretary's judgment that they "are so severe as to preclude substantial gainful activity." *Bowen* v. *Yuckert*, 482 U.S. 137, 141 (1987); see also *Bowen* v. *City of New York*, 476 U.S. 467, 470-471 (1986) (impairments "of sufficient severity to preclude gainful employment"). And even if a claimant's impairment is not included in the Listing, he will be found disabled "if the medical findings are at least equal in severity and duration to the listed findings" (20 C.F.R. 416.926(a)). Thus, like the threshold severity regulation at issue in *Yuckert*, Part A of the Listing of Impairments "adopts precisely [the] functional approach to determining the effects of medical impairments" that was described in *Heckler* v. *Campbell*, 461 U.S. 458, 459-460 (1983). *Yuckert*, 482 U.S. at 146.

The same is true of Part B of the Listing, at issue here. Part B was formulated over a two-year period by medical specialists, including pediatricians, to identify impairments that compare in severity to those that render an adult unable to work. 20 C.F.R. 416.908, 416.924(b). The preamble to the publication of Part B in 1977 stated (42 Fed. Reg. 14,705) that in identifying the criteria that would establish disability—

> these professionals placed primary emphasis on the effects of physical and mental impairments in children, the impact of the impairment on the child's activities, and the restrictions on growth, learning, and development imposed on the child by the impairments. Those impairments which were determined to impact on the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of 'comparable severity' to the adult listing.

As a result, the level of medical severity specified in Part B for each impairment was chosen precisely because it reflected the Secretary's judgment, informed by medical and other experts, regarding the impact of the impairment on a "child's activities" and his "growth, learning, and development."

Moreover, some of the individual listings require explicit functional assessments beyond that implicitly subsumed in the level of impairment severity generally. See §§ 101.03(C), 111.06, and 112.03, quoted at Gov't Br. 42. The recently proposed revision of the Part B mental impairment listing for children illustrates such an elaboration of the Listing approach in some detail. See 54 Fed. Reg. 33,238 (Aug. 14, 1989), reproduced at App., *infra*, 1a-26a.[1] The proposed listing for each of nine categories of mental disorders is divided into two paragraphs. The first identifies the clinical findings that are necessary to substantiate the existence of a mental disorder. The second paragraph then specifies the level of severity that must be shown in order for the impairment to be regarded as disabling; for that purpose, "severity is measured according to the functional limitations imposed by the medically determinable mental impairment." § 112.00C (Preamble); App., *infra*, 7a. To implement this principle, the second paragraph for each mental disorder specifies functional limitations (which vary according to the child's age) that must be present in one or more of four areas of functioning: motor, cognitive/communicative, social,

[1] The comment period on the proposal closed on October 13, 1989. The proposed revisions are largely patterned after the Part A mental impairment listing for adults (§ 12.00), which was revised in 1985, as required by Section 5(a) of the Social Security Disability Benefits Reform Act of 1984, (98 Stat. 1801). See Pet. App. 18a-20a; *City of New York*, 476 U.S. at 486 n.14.

and personal/behavioral. The proposed criteria also specify the requisite degree of departure from the developmental norm for each function. § 112.02B; App., *infra*, 18a-19a. In short, contrary to respondents' contention, there is no inconsistency between the Listing approach and recognition of functional considerations.

2. Nor is there any merit to respondents' contention that the regulations prevent an "individualized" determination of disability. As the Court explained in *Campbell*, 461 U.S. at 467, the Act's provision for individualized determinations based on evidence adduced at a hearing (42 U.S.C. 405(b)) "does not bar the Secretary from relying on rulemaking to resolve certain classes of issues." That is what the Secretary did in promulgating the Part B Listing. The Listing identifies qualifying criteria for particular impairments in children, and thereby also establishes both the general level of impairment severity that underlies the Listing and specific benchmarks against which unlisted impairments may be compared to determine whether they are of equivalent severity. A holding that the Secretary cannot prescribe such standards by rule "would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." *Campbell*, 461 U.S. at 467. Within the framework of the Listing, the claimant is afforded a full opportunity to present medical and other evidence of the nature and extent of his impairment, his daily activities, and other relevant factors, in order to establish that his impairment is of sufficient severity to render him disabled. *Hinckley* v. *Secretary of HHS*, 742 F.2d 19, 23 (1st Cir. 1984); see *Campbell*, 461 U.S. at 467; *Yuckert*, 482 U.S. at 152-153.

3. Respondents, however, seek to require the Secretary to take functional considerations into account in a much different way. They contend that in *every* case in which the Secretary concludes that a child does not have an impairment that meets or equals the Listing, the Secretary must measure the child's "residual functional capacity" (RFC) and then determine whether that RFC – apparently when considered together with unspecified non-medical factors similar to an adult's age, education, and work experience – renders him disabled. See Resp. Br. 14, 16, 22, 23, 24 n.22, 30-32, 43-46.

The approach respondents propose would fundamentally change the focus and structure of the child's disability program

and would cut it loose from its moorings in the objective benchmarks of the Listing. Under the Listing approach, the claimant's eligibility turns on the severity of his impairment, as measured against the criteria in the Listing. By contrast, an RFC assessment does not measure the severity of the impairment itself; rather, it measures "what [the claimant] can still do *despite* [his] limitations" (20 C.F.R. 416.945 (emphasis added)). In other words, the Listing focuses on the extent to which a claimant's functional abilities are limited by his impairment, while RFC focuses on what abilities the claimant has left. Because Section 1382c(a)(3)(A) defines a child's disability in terms of whether his "impairment" is of a specified level of "severity" ("comparable"), it is entirely reasonable for the Secretary to make determinations of disability in children by reference to the Listing, which measures impairment severity, rather than RFC, which does not.[2]

Moreover, respondents lose sight of the fact that the RFC assessment of an adult is not a determination of whether he is disabled. See 20 C.F.R. 416.945(a), quoted at Gov't Br. 7 n.7. The RFC measurement merely aids the adjudicator in deciding whether a claimant whose impairment does not meet or equal the Listing nevertheless is disabled, because he cannot perform his previous work and also cannot (considering his age, education and work experience) engage in any other substantial gainful work in the national economy. In order to decide whether an adult can work despite his impairment, it is necessary to identify his residual capacity to do work-related activities (as well as any limitations resulting from advanced age or limited education and work experience). Thus, RFC is not part of the statutory eligibility standards even for adults; it is only an evaluative device developed by the Secretary for making the assessment, expressly required by Section 1382c(a)(3)(B), of the ability of an adult to work. Because Section 1382c(a)(3)(B) does not provide for an assessment of a child's ability to work or for an individualized consideration of any non-medical factors that are similar to an adult's age, education, and work experience, there is no occasion for the Secretary to consider a child's RFC.[3]

[2] Viewed another way, the total functional capacity that the claimant would have if he were *not* impaired is the sum of: (1) the functional capacity he retains, and (2) the functional capacity he lacks because of his impairment (*i.e.*, the severity of his impairment). There is nothing in 42 U.S.C. 1382c(a)(3), or in the concept of "disability," that requires the Secretary to determine whether a child is disabled by reference to the former component (as respondents urge) rather than the latter (as governing regulations have long required).

B. Despite the reasonableness of the Secretary's regulation establishing the Listing approach, respondents contend that the regulation conflicts with the Social Security Act and therefore is invalid on its face. Respondents and their amici do not seriously dispute our submission (Gov't Br. 19-23) regarding the applicable standard of review. See Resp. Br. 15; AMA Br. 10-11. Both the Listing itself and the regulation requiring a claimant for child's disability benefits to have an impairment that meets or equals the Listing were issued pursuant to the Secretary's " 'exceptionally broad authority' " under 42 U.S.C. 405(a) to prescribe standards for giving content to the statutory definitions of disability. *Yuckert*, 482 U.S. at 145, quoting *Campbell*, 461 U.S. at 466. That general authority is augmented in this case by Section 501(b) of the Unemployment Compensation Amendments of 1976, which directed the Secretary to publish "criteria to be employed to determine disability" in children under 42 U.S.C. 1382c(a)(3). Part B of the Listing consists of the "criteria" that the Secretary published pursuant to that directive. Those criteria—and the corresponding regulation that requires a claimant's impairment to meet or equal the Listing—are entitled to "legislative effect" and are controlling on the courts unless they are " 'arbitrary, capricious, or manifestly contrary to the statute.' " *Atkins* v. *Rivera*, 477 U.S. 154, 162 (1986), quoting *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837, 844 (1984). At the very least, the regulatory requirement respondents challenge is not "manifestly contrary to the statute."[4]

[3] As respondents point out (Br. 31), the regulations provide that RFC is a "medical assessment" (20 C.F.R. 416.945(a))—although, like the medical assessment under the severity regulation and the Listing, it is based on functional considerations (*ibid.*). Contrary to respondents' assertion (Br. 5 n.6, 30-32), we do not argue otherwise in our opening brief. We simply point out (Gov't Br. 6-7, 26, 38) that RFC is measured only for purposes of determining an adult claimant's ability to work.

[4] Respondents assert that the legal issue is a " 'pure question of statutory construction for the courts to decide' " (Br. 15, quoting *INS* v. *Cardoza-Fonseca*, 480 U.S. 421, 446 (1987)) and that "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear Congressional intent" (Br. 15). See also States' Br. 33-36. These assertions ignore the absence of any clear congres-

1. Section 1382c(a)(3)(A) provides that an individual "shall be considered to be disabled • • • if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment • • • (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)." Respondents argue (Br. 17-19) that Congress's use of the word "comparable" prohibits exclusive reliance on the Listing and compels an assessment of RFC and non-medical factors, since the latter are considered in evaluating adults. The word "comparable," which is intrinsically imprecise, will not bear the weight respondents place on it. In fact, Section 1382c(a)(3) as a whole affirmatively supports the Secretary's approach in a number of respects.

a. Respondents err in stating that "Congress instructed the Secretary in 1972 to evaluate the severity of the impairments of children in a *manner* comparable to adults" (Br. 18 (emphasis added)). Section 1382c(a)(3)(A) does not require the Secretary to use "comparable *methodology*" in evaluating children;[5] it states a *substantive* standard of "comparable severity" for impairments. Accordingly, the word "comparable" does not suggest that the Secretary must make an RFC assessment and consider non-medical factors for children simply because he does so for adults.

b. The initial clause of Section 1382c(a)(3)(A) focuses on the consequences of the impairment for an adult (whether he is unable to engage in any substantial gainful activity "by reason of" the impairment), which requires a determination of whether the claimant in fact *is* unable to work. This feature of the initial clause might suggest the need for an evaluative device such as RFC to measure the claimant's capacity for work (although the clause contains no express provision to that effect). But whatever the initial clause may require for adults, the parenthetical clause does not suggest that the Secretary must determine

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sional intent to bar the Secretary's approach and the presence of the delegations of legislative rulemaking authority, under which "Congress entrust[ed] to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term." *Batterton* v. *Francis*, 432 U.S. 416, 425 (1977).

[5] Compare 42 U.S.C. 1396a(a)(10) ("same methodology"), discussed in *Atkins* v. *Rivera*, 477 U.S. at 158; *Schweiker* v. *Hogan*, 457 U.S. 569, 573 n.6 (1982) ("comparable treatment").

whether a child in fact is unable to engage in any "substantial gainful" activity, and it therefore does not furnish a basis for inferring that the Secretary must employ an evaluative device such as RFC. The parenthetical clause instead focuses exclusively on the existence of a medically determinable impairment of a certain level of "severity." It is the Listing, not RFC, that addresses impairment severity. Thus, the text of Section 1382c(a)(3)(A) affirmatively supports the Secretary's Listing approach and substantially undermines respondents' position.

c. The term "severity" has consistently been used in the disability programs to refer to a *medical* assessment (albeit often one based on functional considerations, as under the Listing). *Yuckert*, 482 U.S. at 149 n.7; 42 U.S.C. 1382c(a)(3)(F) (Supp. V 1987). The presence of the term "severity" in the parenthetical clause of Section 1382c(a)(3)(A) therefore supports an evaluation based on medical factors alone, without considering vocational or other non-medical factors (and RFC), as in the case of an adult. This conclusion is reinforced by Section 1382c(a)(3)(B), which expressly provides for individualized consideration of non-medical factors (age, education, and work experience) for adults but omits any such reference to non-medical factors for children and omits any parenthetical "comparability" clause, such as that in paragraph (A), that might have served the same purpose. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982). The legislative history, moreover, confirms this reading of the text: The House Report describes the evaluation prescribed by Section 1382c(a)(3)(B) as applicable to individuals "other than a child under age 18" (H.R. Rep. No. 231, 92d Cong., 1st Sess. 148 (1971)).

d. Contrary to respondents' view (Br. 18-19), one of this Court's decisions upon which they rely makes clear that "[c]omparable • • • does *not* mean identical" (*Wheeler* v. *Barrera*, 417 U.S. 402, 420 (1974) (emphasis added)). For this reason, in establishing the general level of impairment severity that will lead to a finding of disability and identifying particular impairments that attain that level, the children's Listing need not correspond precisely to the level of severity that is generally applicable to adults or include every impairment that would lead the Secretary to find some or all adults disabled.

e. The foregoing conclusion is supported by the operation of the sequential evaluation process that has been implemented

for adults under Section 1382c(a)(3)(A) and (B). It is true that an adult whose impairment does not meet or equal the Part A Listing at step three of that process may be found disabled at step five—if, in light of his age, education and work experience, he is unable to perform any substantial gainful work that exists in the national economy. But in that event, the basis of the disability finding is not the "severity" of his impairment standing alone, but rather the severity of the impairment *plus* an adverse vocational factor, such as advanced age, a relative lack of education, or limited work experience.[6] The claimant's impairment therefore is *not* one that would lead adults to be found disabled as a general matter, since all adults who did not also have one or more adverse vocational factors would be denied benefits. Accordingly, contrary to respondents' contention (Br. 19), if the same non-listed impairment was present in a child, it would *not* be one of "comparable severity" to an impairment that necessarily would render an adult disabled. A finding that a child having such an impairment is not disabled therefore is entirely consistent with the text of Section 1382c(a)(3)(A).[7]

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[6] See SSR 86-8, West Soc. Sec. Rept. Serv. (Rulings) 510 (Supp. 1989) ("Under the regulations, a finding that an individual's impairment(s) does not meet or equal the Listing effectively indicates that he or she has a sufficient work capability at the sedentary or a higher exertional level, to require medical-vocational evaluation."); 43 Fed. Reg. 55,353 (1978) ("If * * * an individual does not have the physical-mental capacity to perform work even at a sedentary level[,] * * * the individual should ordinarily have been determined to be disabled based solely on consideration of the medical severity of impairment under [the Listing]").

[7] Experience has shown over the past 14 years that in the substantial majority (usually more than 75%) of cases in which adults have been found to be disabled, the claimant met or equaled the Listing. See House Comm. on Ways & Means, 101st Cong., 1st Sess., *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 46 (Table 2) (Comm. Print 1989), reproduced at Nat. Org. of Soc. Sec. Clmnts' Reps. Br. A2. This experience further corroborates that the "comparable severity" standard is satisfied under the Secretary's approach, because it shows that the substantial majority of adult claimants have impairments of a level of severity that is comparable to the level embodied in the Part B Listing for children.

Respondents are correct that the "guides" (now the Listing) were not originally developed in the 1950s to be a dispositive basis for disability determinations, since vocational factors were to be taken into account for the wage-earner claimants then covered by the Title II program. See Br. 21-22, 24. But from the outset, it was intended that the "great majority" of claims would be determined on the basis of medical factors alone, including through use of the

2. Respondents argue (Br. 26-36) that the Listing requirement in the regulations is not entitled to deference because it was not contemporaneously adopted by the Secretary and has not been consistently maintained. This argument is conclusively refuted by the history of the regulations.

a. The SSI program went into effect on January 1, 1974. Gov't Br. 2 n.1. On January 11, 1974, the Secretary published proposed regulations governing determinations of disability under the SSI program. 39 Fed. Reg. 1624 (1974). The regulation relevant here stated that "[d]isability shall be deemed to exist for a child under age 18" if: (1) the child is not engaging in substantial gainful activity, (2) his impairments satisfy durational requirements, and (3) his impairments "are listed in the appendix" or, if not listed, are determined by SSA, "with appropriate consideration of the particular effect of disease processes in children," to be "medically the equivalent of a listed impairment." *Id.* at 1626, adding 20 C.F.R. 416.904; see also 40 Fed. Reg. 31,778, 31,783 (1975) (final regulation). Thus, the regulatory requirement respondents challenge was instituted at the very outset of the SSI program.

That requirement has been reaffirmed and consistently maintained ever since. In March 1977, after Congress directed the Secretary to publish "criteria" for determining disability in children, the Secretary published a revision of 20 C.F.R. 416.904, which again stated that a child under age 18 must meet or equal the Listing, including a new Part B of the Listing, which contained the statutorily mandated "criteria" for making determinations under 416.904. 42 Fed. Reg. 14,705 (1977). And when the Secretary thoroughly revised the disability regulations in 1980, he again retained the Listing requirement for children (45 Fed. Reg. 55,625, adding 20 C.F.R. 416.923), specifically rejecting the contention, now advanced by respondents, that it is inconsistent with the "comparable severity" language in Section

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guides. SSA, *Disability Freeze State Manual* § 304.B (1955) (copy lodged with the Clerk); see also *Administration of Social Security Disability Insurance Program: Hearings Before the Subcomm. on the Administration of the Social Security Laws of the House Comm. on Ways and Means*, 86th Cong., 1st Sess. 342-343 (1959) (90% of allowances based on meeting or equaling the listing). Nothing in the early experience suggests that the Listing is an inappropriate basis for disability determinations where, as here, vocational factors are not considered and disability is based on medical factors alone.

1382c(a)(3)(A). 45 Fed. Reg. 55,570-55,571 (1980). The regulation has remained in effect ever since. See 20 C.F.R. 416.924 (1988).

b. Respondents attempt to negate the contemporaneous and longstanding interpretation embodied in the Secretary's published regulations by asserting (Br. 27-32) that SSA took a different position in Disability Insurance Letter (DIL) No. III-11 (J.A. 89-93) and the Supplement thereto (J.A. 94-114), which were transmitted to the state agencies on September 7, 1973, and January 9, 1974, respectively. This assertion is equally baseless. DIL III-11 explicitly stated that "childhood disability will be determined solely in consideration of medical factors" and that "[v]ocational factors *will not* be considered" (J.A. 91). The Supplement was transmitted contemporaneously with the publication of the SSI disability regulations in January 1974, and it stated that the regulations "specifically require[ ] that a child's impairment or impairments must either *meet* or *equal* the listing of impairments" (J.A. 95). The remainder of the Supplement was devoted to explaining how the adult Listing would be applied to children, how a separate set of criteria for children would be developed out of informal guides, how the equivalence concept operated, and how evidence of the impairment's impact, the child's school activities, developmental milestones, and other factors could be taken into account in determining whether a child's impairment satisfied the level of severity in the Listing (J.A. 95-100). Although these two transmittals obviously support our position that the special criteria for children have been firmly rooted in functional considerations from the outset, neither contains the slightest support for respondents' assertion (Br. 28, 30-31, 35, 41-42) that the Secretary was contemplating something other than a requirement that a child's impairment must meet or equal the Listing.

3. Respondents also take issue (Br. 37-42) with our submission (Gov't Br. 32-33) that the Listing requirement derives still further support from Section 501(b) of the Unemployment Compensation Amendments of 1976. However, they entirely ignore the explicit text of that statute. Section 501(b) directed the Secretary to "publish criteria to be employed to determine disability (as defined in [42 U.S.C. 1382c(a)(3)]) in the case of persons who have not attained the age of 18." The term "criteria" connotes specific "standard[s] on which a decision or

judgment may be based"—"yardstick[s]" against which the severity of impairments may be measured. *Webster's Third New International Dictionary* 538 (1976) ("criterion"). It thus aptly describes the detailed standards in the Listing of Impairments, and indeed the introduction to both Part A and Part B of the Listing uses the term "criteria" to describe those standards (J.A. 115, 206). Furthermore, Section 501(b) states that the criteria in the Listing are to "determine" the question of disability in children. The text of Section 501(b) therefore refutes respondents' position (Br. 19 n.17) that the Secretary may not use the Listing as anything more than a screening device, and that the criteria in the Listing may never be the "sole determinant" of disability.

The legislative history of Section 501(b) confirms this interpretation and shows that Congress fully understood that the published "criteria" would *implement* the Listing approach, not depart from it, as respondents contend (Br. 40-41). The Senate Report, quoting the regulation published by the Secretary in January 1974, specifically noted that "[t]he regulations that have been issued with regard to disability for children state that if a child's impairments are not those listed," the child may still be found eligible if his impairments are found " 'to be medically the equivalent of a listed impairment.' " S. Rep. No. 1265, 94th Cong., 2d Sess. 24 (1976). The Report further noted that the Secretary had for some time been circulating draft regulations "with criteria for child disability," but that they had "not yet been issued." *Id.* at 25. The purpose of Section 501(b) was to dislodge those criteria from SSA. Respondents' contrary notion—that the Senate Committee expected the Secretary to abandon the Listing-only approach—cannot be squared with Section 501(b)'s allowance of only 120 days for the Secretary to complete the task, a period that would have been insufficient to design an entirely new regulatory approach, as respondents now urge.

The Senate Report also underscores the congressional purpose to require the Secretary to develop "objective criteria" (*id.* at 25) and "more definitive guidelines" to replace the "statements" and "temporary guidelines" that SSA had previously furnished to the States in DIL III-11 and its Supplement in 1973 and 1974 (*id.* at 24). In the Committee's view, publication of the

criteria would "end the present uncertainty which the State agencies and others have with regard to what constitutes disability in a child" and provide an "equitable basis" for administering the program. *Id.* at 25; accord 122 Cong. Rec. 33,301 (1976) (Sen. Long); *id.* at 33,302 (Sen. Bayh). The amorphous RFC approach respondents urge would conflict with those goals.

Respondents attempt to blunt the force of the Senate Report by relying (Br. 38) on excerpts from a floor statement by Representative Mikva concerning a bill that would have directed the Secretary to promulgate "criteria (including medical, social, personal, educational, and other criteria) for the determination of disability" in children. H.R. 8911, 94th Cong., 2d Sess. § 4(e) (1976); 122 Cong. Rec. 27,883 (1976). Significantly, however, the reference to "medical, social, personal, educational and other criteria" was omitted from Section 501(b) as finally enacted. In any event, Representative Mikva's remarks in fact support the Secretary's Listing approach. He described the bill as requiring "specific and standardized disability criteria for children" (122 Cong. Rec. 27,855 (1976)), which is exactly what the Listing consists of. His further statement that those criteria should "take into account not only the medical development of the child but also the child's social, educational, and personal development" (*ibid.*) is fully consistent with the Listing approach as well. The general level of impairment severity in Part B takes into account the impact of impairments on a child's growth and development, and the proposed revision of the mental impairment listing provides for an even more particularized assessment in this regard.[8]

C. In addition to challenging the Listing requirement, respondents and their amici criticize certain aspects of the Listing itself, the manner in which it has been applied to particular diseases or even particular claimants, and certain other features of the disability determination process. These criticisms

[8] The post-debate statement of Senator Hathaway, upon which respondents also rely (Br. 39), likewise is fully consistent with the Secretary's Listing approach. Indeed, the Senator acknowledged that "[m]edical criteria used in the broad sense of the total health development of the child could indeed provide the basis for determining the comparable severity of a child's impairment." 122 Cong. Rec. 34026 (1976).

are largely unfocused and unrelated to the single but significant legal issue in this case concerning a facial challenge to the Listing requirement.[9] As the district court observed, "[i]f these [Listing] criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree" (Pet. App. 24a).[10] Similarly, if any of the

[9] For example, respondents speculate (Br. 20, 24 & n.22, 32) that a child's multiple impairments might not be adequately evaluated. However, 42 U.S.C. 1382c(a)(3)(F) (Supp. V 1987), specifically requires that the combined effect of multiple impairments be considered in every case (*Yuckert*, 482 U.S. at 149-152), and that requirement is implemented by regulations (20 C.F.R. 416.923, 416.926(a)) and SSR 83-19 (J.A. 239). Similarly, although respondents speculate about how allegations of pain are considered, they acknowledge that there are statutory and regulatory provisions governing that issue as well. Br. 24 n.22, 31-32; see 42 U.S.C. 1382c(a)(3)(G) (Supp. V 1987); SSR 88-13, West Soc. Sec. Rept. Serv. (Rulings) 737-738 (Supp. 1989). Several sections of the Listing identify pain as a relevant factor (§§ 1.00A&B, 4.00D&E, 101.00A (J.A. 116-117, 141-142, 208)), and pain may be taken into account where it results in functional limitations. Any issues concerning the application of these standards must await individual cases in which those issues are actually presented.

[10] Respondents argue (Br. 24-25, 32-33) that application of the concept of equivalency to a listed impairment might not sufficiently take into account functional consequences of the unlisted impairment. They first criticize (Br. 32-33) the Secretary for what they view as a departure from the Supplement to DIL III-11 in 1974, which urged reliance on equivalence to decide difficult cases. See J.A. 97. However, that advice was given before SSA had fully developed separate Listing criteria specifically for children's impairments, and it therefore was necessary to compare such impairments to the adult criteria. The issuance of the detailed children's criteria in 1977 has diminished the need for reliance on the equivalency concept.

Respondents also object (Br. 24, 32-33) that SSR 83-19 unduly limits consideration of the functional impact of an unlisted impairment in deciding whether it equals a listed impairment. The passages on which they rely for this assertion state that equivalency cannot be based on an assessment of "overall functional impairment" (J.A. 239) or RFC (J.A. 240). These passages merely reiterate that the Listing approach focuses not on RFC or the claimant's overall capacity *despite* his impairment, but rather on the severity of the impairment itself. Contrary to respondents' view, SSR 83-19 was not intended to bar consideration of the functional impact of an unlisted impairment in deciding whether it is equal in severity to a listed impairment. We have been informed by HHS that consideration is being given to a possible clarification of SSR 83-19 on this point.

Respondents assert (Br. 32 n.29) that the number of equivalency findings began to "drop precipitously" after SSR 83-19 was issued. In fact, the Committee Print upon which they rely (see note 7, *supra*) shows that the decline

amicus groups believe that the Listing does not adequately address certain types of impairments or should be updated, they may petition the Secretary to initiate a rulemaking proceeding to revise particular criteria or may participate in on-going proceedings for that purpose.[11]

These scattershot criticisms should not, however, be permitted to obscure the significant conceptual, policy and pragmatic difficulties with the RFC approach respondents propose in this case. Most critically, respondents do not offer any meaningful articulation of an appropriate benchmark, similar to an adult's ability to work, against which decision-makers would measure a child's RFC; nor do they describe the manner in which a disability determination would be made on the basis of a child's RFC. The most basic question of course is: residual functional capacity to do what? Amici AMA, et al., concede "that for children there is no single benchmark for conducting a functional analysis like employment for adults" (Br. 21). Respondents suggest in passing (Br. 45) that the RFC assessment might measure the child's residual capacity to engage in "age-appropriate activities."[12] But would eligibility depend on an

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began well before SSR 83-19 was issued, and it corresponded with an increase in the number of findings that an impairment met the Listing. This development reflects the evolution of the criteria in the Listing as a reliable measure of impairment severity. A study of the child's disability program upon which respondents otherwise rely concludes that children with single diseases that are not included in the Listing are not unduly hindered in establishing eligibility. Fox & Gearney, *Disabled Children's Access to SSI and Medicaid Benefits* 47-51 (1988). Although respondents point out (Br. 23) that this study was "funded by the Secretary," they fail to point out that it was released with a disclaimer (a copy of which is lodged with the Clerk) because its data were not regarded as statistically valid.

[11] The fact that the Listing might not mention a particular disease or condition by name does not in itself suggest a gap in the Listing, as respondents and amici intimate. The manifestations of that disease or condition may nonetheless be found to meet or equal the Listing. For example, we have been informed by SSA that the vast majority of children with Down Syndrome are found to the be disabled, even though that Syndrome is not yet included, as such, in the Listing. See note 16, *infra*.

[12] Respondents erroneously argue (Br. 45) that the Secretary has endorsed an "age-appropriate activities" approach for children in the regulations implementing the medical improvement standard in 42 U.S.C. 1382c(a)(5) (Supp. V 1987). Under those regulations, medical improvement is deemed to

inability to engage in *any* age-appropriate activities, just as Section 1382c(a)(3)(A) requires an adult to show that he cannot engage in "*any* substantial gainful activity"? If an inability to perform only *some* age-appropriate activities would suffice, which ones would they be? How far below the norm would the claimant's residual capacity have to fall, and would his deficiency be measured in the aggregate or for each age-appropriate activity? What non-medical factors (similar to an adult's age, education and work experience) would be considered together with the child's RFC: His education? Social experience? Family background? Intellectual and emotional development? And would normal or above-normal ratings for some non-medical factors offset adverse aspects of others?

In addition, because physical, mental and emotional development varies widely even among unimpaired children, it might often be difficult for an adjudicator to determine how much of a child's deficit in a particular area is attributable to an impairment and how much is within an acceptably "normal" range. It might also be difficult to measure or quantify a child's *overall* residual functional capacity, especially in young children. Because of these difficulties, decisions concerning each claimant's overall ability to engage in age-appropriate activities (in light of his RFC and whatever non-medical factors were deemed

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have occurred in a child (which then permits the Secretary to evaluate the claimant under generally applicable standards) "if there has been any medical improvement in [the claimant's] impairment(s)" and if "this medical improvement is related to [the claimant's] ability to work (i.e., [his] ability to perform age-appropriate activities)." 20 C.F.R. 416.994(c) and (1)(ii). These regulations merely identify in general terms the minimal nexus that must be found as a threshold matter between the improvement in the child's medical condition and his relevant functional abilities. If this nexus is present, the test of disability is not whether the child can perform "age-appropriate activities," but whether his impairment meets or equals the Listing. See 20 C.F.R. 416.994(c).

Respondents also err in relying (Br. 44-45) on the Title II provision for payment of insurance benefits to a wage-earner's adult child who became disabled before age 22. That provision expressly requires the child to satisfy the standard of disability for adults under 42 U.S.C. 423(d) (see 42 U.S.C. 402(d)(1)(B) and (G)), and therefore requires a showing that the claimant cannot perform any substantial gainful activity. It is for this reason that such claimants are evaluated under the five-step sequential evaluation process for adults. The RFC assessment in such a case of course focuses on the claimant's capacity to perform *work* activities, not "age-appropriate activities."

relevant) might be unduly subjective and ad hoc, thereby undermining the statutory goal of uniformity among the thousands of adjudicators in the state agencies and SSA. See 42 U.S.C. 421(a)(2); *Heckler* v. *Day*, 467 U.S. 104, 116 (1984).

Respondents and their amici do not offer any answers to these and other questions raised by the RFC approach they urge. Moreover, there can be no claim that *Congress* has supplied any of these answers. See AMA Br. 14 ("Congress did not set out specific functions that children perform that could be compared directly to ability to work for adults."). At bottom, what respondents seek is a judicial restructuring of the child's disability program based on ill-defined notions that Congress has not adopted. Whatever the merits of their proposal, it is addressed to the wrong forum. There simply is no warrant for the courts to undertake the task of redesigning the child's disability program from the bottom up under the guise of interpreting the ambiguous words "comparable severity."

D. We do not suggest that the child's disability program is free of any difficulties or errors. It is a program of substantial dimensions that must respond to genuine needs, rapid medical and technological advances, and the imperatives of equitable, efficient and uniform adjudication. Its administration therefore requires difficult and expert judgments concerning public and statutory policy and sound administration. Congress has vested responsibility for those matters in the Secretary in the first instance, subject to plenary legislative oversight but only limited judicial review.

Congress in fact is now considering proposals for formal studies and possible revisions of the child's disability program. The budget reconciliation bill passed by the House of Representatives on October 5, 1989, would amend the Act, effective October 1, 1989, to provide the first express statutory directive for an "individualized assessment" of a child's impairments "that prevent or significantly interfere with the activities of daily living appropriate to the age of the child." H.R. 3299, 101st Cong., 1st Sess. § 10,222 (1989) (135 Cong. Rec. H6131 (daily ed. Sept. 27, 1989)); see House Comm. on Ways & Means, 101st Cong., 1st Sess., *Summary of Budget Reconciliation Provisions Under The Jurisdiction of the Committee on Ways and Means*

31-32 (Comm. Print 1989).[13] The Senate Finance Committee's recommendations for the bill instead would provide for a 15-member Commission to study the definition of disability in children, whether an individualized functional assessment would be appropriate (and what criteria might be employed), and how Part B of the Listing should be revised. 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989).[14] The Secretary also has conducted an internal study of children's claims,[15] has instituted revisions of the Part B Listing,[16] and is considering various other measures, including the broader use of pediatricians in evaluating claims and more intensive review by SSA of state-agency adjudications. *Preliminary Report*, Tab F. Especially in view of this intensive scrutiny and possible revisions of the child's disability program by both the Secretary and Congress,

[13] The House bill also would establish a rule of presumptive disability for certain children under age 4 with genetic or congenital impairments, including cystic fibrosis, Down's syndrome, Tourette syndrome, Prader Will syndrome, and spina bifida (§ 10,223), and require that the mental impairment and other children's listings be revised (§§ 10,224, 10,225).

[14] The Committee's recommendations also would provide for the commission to study the validity of the presumption of disability proposed by the House bill for certain young children (see note 13, *supra*), require pediatricians to participate in disability determinations, and mandate review by SSA of 50% of all state-agency denials of child's disability claims. 135 Cong. Rec. S13,205-S13,206 (daily ed. Oct. 12, 1989).

[15] See SSA, Office of Disability, *Preliminary Staff Report: Childhood Disability Study*, Tab E, at 1 (Sept. 20, 1989) (copy lodged with the Clerk). The study revealed a high error rate for several categories of impairments: growth impairments (42%), cardiovascular (29%), and digestive (13%). *Id.*, Tab D, at Table 3. The results of this study led to the Finance Committee's recommendation that SSA review 50% of all state agency denials. 135 Cong. Rec. S13,205 (daily ed. Oct. 12, 1989).

[16] Because approximately 60% of child's disability claims involve allegations of mental impairments (*Preliminary Report*, Tab E, at 1), the final revision of the mental impairment listings will have a broad impact. New listings for Down Syndrome and other Hereditary, Congenial and Acquired Disorders, which were proposed in October 1987 (52 Fed. Reg. 37,161), are scheduled for final publication in February 1990. *Preliminary Report*, Tab F, at 1. Proposed revisions in the children's musculoskeletal and cardiovascular listings are in the latter stages of administrative review prior to publication of a notice of proposed rulemaking. *Ibid.*

the Court should reject respondents' request for a judicial restructuring of the way in which that program has been administered since 1974.

For the foregoing reasons and those stated in our opening brief, it is respectfully submitted that the judgment of the court of appeals should be reversed.

KENNETH W. STARR
Solicitor General

OCTOBER 1989

APPENDIX

NOTICE OF PROPOSED RULEMAKING
54 Fed. Reg. 33,238 (Aug. 14, 1989)

Proposed Revision of Medical Criteria for Evaluating Mental Disorders of Children Under Age 18.

* * * * *

The proposed revisions serve several purposes. The medical terms used to describe the major mental disorders of childhood and their characteristics and symptoms have been updated to conform to the nomenclature currently used widely by psychiatrists, psychologists, and other mental health professions. Terminology in the listings is based on that used in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III) published by the American Psychiatric Association (APA) in 1980. This edition gives a common basis for communication, which is particularly important in evaluating medical reports used in determining disability. The DSM III-Revised, which was published in May 1987 and after these evaluation criteria were developed, does not differ in its applicable terminology.

The proposed listings are also more specifically related to distinct types of mental disorders. Thus, fewer disorders are included under the same listing than are grouped together under the current listings. The result is an increase in the number of listings from four to nine. In the proposed listings, the organization of mental disorders is based on the DSM III which provides a realistic organization in terms of the common characteristics of the mental disorders that are evaluated under a particular listing. The more recently published DSM III-Revised does not differ in its organization.

Since the body of knowledge on the characteristics, treatment and management of mental disorders in children

is constantly evolving, the Social Security Administration (SSA) will provide for the ongoing evaluation of the medical criteria for evaluating mental disorders in children to ensure that the criteria reflect the most up-to-date knowledge on those disorders.

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The following is a summary of the proposed listings.

112.00 Preface

We are proposing several significant additions to the preface to the mental disorders listings for children under age 18. Proposed Introduction, 112.00A of the preface explains the basic approach used in the listings that follow. It explains that most of the listings use a new dual approach which divides each listing into two paragraphs: the first paragraph (the A paragraph) describes the characteristics necessary to substantiate the existence of the mental disorder, while the second paragraph (the B paragraph) describes the applicable restrictions and functional limitations which result from the disorder in children.

In 112.00B of the preface, Need for Medical Evidence, we describe the need for medical evidence to substantial [*sic*] the existence of a medically determinable impairment.

In 112.00C of the preface, Assessment of Severity, we describe in detail the multiple factors in the paragraph B criteria of most listings which pertain to functional limitations and restrictions in various age groups in children. This significant revision in the mental disorders listings has been introduced because mental health professionals consider such factors particularly important in evaluating mental disorders of children. It should be noted that although the items in paragraph B are identical for most listings, the number of items required varies for particular listings.

In 112.00D of the preface, Documentation, we discuss the evidence needed to document mental disorders in children.

In 112.00E, Effect of Hospitalization of Residential Placement, and 112.00F, Effects of Medication, we also include new information relating to mental disorders in children. This material explains that evaluation of mental disorders must include consideration of the fact that medications, hospitalizations, or other highly structured living arrangements may minimize the overt indications of severe chronic mental disorders without necessarily affecting the functional limitations imposed by the disorder. The proposed 112.00F also acknowledges that medications may sometimes produce side effects that add to the functional limitations resulting from mental disorders in children.

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For the reasons set out in the preamble, Part 404, Subpart P, and Part 416, Subpart I, of Chapter III of Title 20, Code of Federation Regulations is amended as set forth below.

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4. Part B of Appendix 1 (Listing of Impairments) of Subpart P is amended by revising 112.00, Mental and Emotional Disorders, to read as follows:

112.00 Mental Disorders

A. *Introduction:* The structure of the mental disorders listing for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 9 diagnostic categories: Organic mental disorders (112.02); psychotic

disorders (112.03); affective disorders (112.04); mental retardation (112.05); anxiety-related disorders (112.06); disorders with physical manifestation (112.07); personality disorders (112.08); autism and other pervasive developmental disorders (112.09); and developmental and emotional disorders of infancy (112.10).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults, hence the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, a finding such as an infant's failure to mold or bond with the parent(s) has grave prognostic implications and serves as a finding comparable in severity to the findings that mark mental disorders in adults.

The activities appropriate to children such as learning, growing, playing, maturing, and school adjustment are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the syndrome or syndromes addressed by the listing. This is followed (except in listings 112.05, 112.08 and 112.10) by clinical findings (paragraph A criteria), which, if satisfied, lead to an assessment of functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular

mental disorder. Specific signs and symptoms under any of the listings 112.02 through 112.10 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the clinical findings.

Paragraph A of the listings is a composite of clinical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of clinical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to infants and young children; whereas in 112.02A1, developmental arrest, delay or regression, are appropriate criteria for infants and young children. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the clinical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06 as are found in the adult listings because, for the most part, we do not believe that

categories like residual schizophrenia or agoraphobia are commonly found in children. However, in individual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05), Personality Disorders (112.08) and Developmental and Emotional Disorders of Infancy (112.10) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains four criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.08 (Personality Disorders) is a reference listing referring the evaluator to listing 12.08 of the adult listings. Listing 112.10 (Developmental and Emotional Disorders of Infancy) contains four criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

Need for Medical Evidence: The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of signs, symptoms and/or laboratory, psychological or developmental test findings. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development and contact with reality as described by an appropriate medical source. Symptoms are complaints presented by the child. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders) described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. *Assessment of Severity:* In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The criteria address age-appropriate functional limitations for each age group in some or all of the following areas: motor function, cognitive/communicative function, social function and personal/behavioral function. In most functional areas two separate methods of documenting the required level of severity are: use of standardized tests (where appropriate test instruments are available) and use of clinical findings. The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and young infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.10 for Developmental and Emotional Disorders of Infancy for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative and social functions.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to the individual infant listing 112.10. These age groupings are: infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the following discussion on the age-appropriate areas of function is broken down into four age groupings, i.e., infants and toddlers (age 1 to attainment of age 3), preschool

children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12) and adolescents (age 12 to attainment of age 18). This was done to better explain the age group variances in disease manifestations and methods of evaluation.

1. *Infants and toddlers (age 1 to attainment of age 3).* In this age group, impairment severity is assessed in three areas: motor development, cognitive/communicative function, and social function. In infancy, much of what we can discern about mental function comes from observation of the degree of fine and gross motor function. Developmental delay as measured by a good developmental milestone history confirmed by medical examination is critical. If the delay is such that the infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D; care should be taken to avoid reliance on screening devices, which are not considered to be sufficiently reliable instruments, although such devices may provide some relevant data.

For infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs is provided.

Social function in infants and toddlers is measured in terms of the development of relatedness (i.e., bonding, stranger anxiety, etc.) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative

criteria that describe marked impairment in socialization in terms of separation anxiety, withdrawal and failure to develop appropriate response to external stimuli.

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescents, the functional areas used to measure severity are: cognitive/communicative function, social function, and personal/behavioral function. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale I.Q. of 69 or less. The listings also provide alternative criteria consisting of tests of language development of bizarre speech patterns.

Social function is measured by relationships with parents, other adults, and peers.

Personal/behavioral function may be measured by a standardized test of adaptive behavior or by careful description of serious maladaptive or avoidant behaviors.

3. *Primary school children (age 6 to attainment of age 12).* The measures of function here are similar to those for preschool-age children except that the test instruments may change and the capacity to function in the school setting supplements information in the cognitive and social parameters. Scores which are at least two standard deviations below the age-appropriate norm on standardized measures of academic

achievement represent a marked impairment in function. As described in 112.00D, Documentation, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children are provided for this age group. It should be remembered, however, that mental disorders in adolescence may more closely resemble those of adults than children. Therefore, if, based on the description of the disorder by the clinician, the adjudicator believes the medical criteria of Part B do not apply, the adult listing criteria will be used.

Again, the same three general areas of function as in the primary school group (cognitive/communicative, social, and personal/behavioral) are measures of severity for this age group. Testing instruments appropriate to adolescents should be used. Comparable clinical findings of disruption of social function must consider the capacity to form appropriate, stable and lasting relationships. If information is available about cooperative working relationships in school or at part or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social and/or personal/behavioral functioning. Markedly impoverished social contact, isolation, withdrawal, or inappropriate or bizarre behavior under the stress of socializing with others also constitutes comparable clinical findings.

The intent of the functional criterion described in paragraph B2d common to the listings, i.e., deficiencies of concentration, persistence or pace resulting in failure to complete work-like tasks in a timely manner is to identify the school-age child age 6 to attainment

of age 18 who cannot adequately function in school because of a mental impairment. Although grades and the need for special education placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

Where "marked" is used as a standard measuring the degree of limitation, except as defined in 112.00C3, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function independently, appropriately, and effectively. When standardized tests are used as the measure functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

D. *Documentation:* The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical information. See §§ 404.1513 and 416.913. Description of functional limitations may be available from these sources and may be supplemented by reports from parents or other concerned adults who aware of the child's activities of daily living, social functioning, and ability to adopt to different settings and expectations.

For very young infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital

anomalies, it may be necessary that some cases be held until the child attains 3 months of age in order to obtain adequate observation of behavior or emotional affect. This period would be extended in cases of premature infants proportionately to the degree of prematurity.

For very young infants and toddlers, programs of early intervention involving occupational, physical and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations as records on the fine and gross motor functioning of an infant. This information is valuable and can complement the medical examination by a physician. The report of interdisciplinary team which contains the evaluation and signature of an acceptable medical source can be considered acceptable medical evidence rather than supplemental data.

In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

In some cases where the treating source(s) lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist or psychologist with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every effort should be made to obtain the records of treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

For purposes of these childhood mental disorders listings, standardized psychological testing indicates the use of a psychological test that has appropriate characteristics of validity, reliability, and norms, administered individually by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as a set of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: 1) validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; 2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and 3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WISC-R, for example, IQ's of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ score(s) to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by the IQ score(s).

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQ's are provided as on the WISC-R, the lowest of these is used in conjunction with listing 112.05.

Tests meeting the above requirements are acceptable and encouraged for the determination of the conditions contained in the childhood mental disorders included in the listings. The psychiatrist or psychologist administering the test must have a sound technical and professional understanding of the tests and be able to evaluate the research documentation related to the intended application of the test.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination level of functioning. These tests do not have high validity and reliability and are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially severe impairments, but must be supplemented by the use of formal, standardized psychological testing for the purposes of a final disability determination where such tests are required and available.

Where reference is made to developmental milestones, this is defined as the achievement of a particular mental or motor skill at an age-appropriate level, i.e., the skills achieved by an infant or young child sequentially and within a given time period in the motor and manipulative areas; in general understanding and social behavior; in self-feeding, dressing, and toilet training; and in language. This is sometimes expressed as a developmental quotient (DQ), or the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, the Gesell Developmental Screening Test, and the Revised Stanford-Binet. Formal tests of the achievement

of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

Formal psychological tests of cognitive achievement are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

Exceptions to formal standardized psychological testing, when required, may be considered when a psychologist or psychiatrist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate historical, social, medical and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests which are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the preceding standardized tests. Any required tests must be administered in the child's principal language.

"Neuropsychological testing" refers to the administration of standardized tests which are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: attention/concentration, problem solving, language, memory, motor, visual-motor and visual-perception, laterality and general intelligence (if not previously obtained).

E. *Effect of Hospitalization or Residential Placement:* As with adults, children with mental disorders may be placed in a variety of structured settings out-

side the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functionable ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

F. *Effects of Medication:* Attention must be given to the effect of medication on the child's signs, symptoms and ability to function. While psychoactive medications may control certain primary manifestations of mental disorder, e.g., hallucinations, impaired attention, restlessness or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body

systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 Category of Impairments, Mental

112.02 Organic Mental Disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and associated impairment of functional abilities.

The required levels of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a deficit or loss of specific cognitive abilities or affective changes as medically documented by the persistence of at least one of the following:

1. Developmental arrest, delay or regression; or
2. Disorientation to time and place; or
3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
4. Perceptual or thinking disturbance (e.g., hallucinations, delusions); or
5. Disturbance in personality; or
6. Disturbance in mood; or
7. Emotional liability (e.g., explosive temper outbursts, sudden crying, etc.); or
8. Impairment of impulse control (e.g., disinhibited social behavior); or
9. Impairment of cognitive function as demonstrated by neuropsychological assessment; and

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development 50 percent or less of the anticipated developmental norm documented by:

(1) An appropriate standardized test; or

(2) Clinical findings (see 112.00C of the preface); or

b. Cognitive/communicative function 50 percent or less of the anticipated developmental norm as documented by:

(1) An appropriate standardized test; or

(2) Clinical findings of equivalent cognitive/communicative abnormality such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts; or

c. Social function 50 percent or less of the anticipated developmental norm documented by:

(1) An appropriate standardized test; or

(2) Clinical findings of an equivalent abnormality of social functioning as exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. A score of 65 percent or less of the anticipated developmental norm in two or more areas covered by a., b., or c. as measured by an appropriate standardized test or the appropriate clinical findings.

2. For children (age 3 to attainment of age 18), resulting in at least one of the following:

a. Marked impairment in age-appropriate cognitive/communicative function as documented by clinical examination and supported, if necessary, by the

results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning as documented by history and clinical examination and supported, if necessary, by the results of appropriate standardized tests; or

c. Marked impairment in personal/behavioral function as evidenced by:

(1) Marked restriction of age-appropriate activities of daily living as documented by history and clinical examination and supported by, if necessary, appropriate standardized psychological tests; or

(2) Persistent serious maladaptive behaviors destructive to self, others, animals or property requiring protective intervention; or

d. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete work-like tasks in a timely manner.

112.03 Psychotic Disorders: Characterized by a marked disturbance of thinking, feeling, and behavior. Occasionally psychotic disorders of adolescence must be more appropriately assessed under listing 12.03 of Part A of Appendix 1 because the medical criteria of this Part do not apply.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, for at least six months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech, with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect; or

4. Emotional withdrawal and/or isolation; and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.04 Affective Disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome associated with at least four of the following:

a. Anhedonia, apathy or pervasive loss of interest in almost all activities; or

b. Appetite disturbances with change in weight or failure to make expected weight gains; or

c. Sleep disturbance (e.g., insomnia or hypersomnia); or

d. Psychomotor agitation, psychomotor retardation or hypoactivity; or

e. Fatigue or loss of energy; or

f. Feelings of worthlessness, self-reproach, or guilt; or

g. Difficulty concentrating or thinking; or

h. Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic or hypomanic syndrome associated with at least three of the following:

a. Increased activity or physical restlessness; or

b. Increased talkativeness or pressure of speech; or

c. Flight of ideas or subjectively experienced racing thoughts; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking; or

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes); and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.05 Mental Retardation: Characterized by significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested in the developmental period. The scores specified below refer to those obtained on the WISC-R, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning. See 112.00D.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Achievement of a pattern of developmental milestones generally acquired by children no more than one-half the child's chronological age; or

B. A valid performance, verbal or full scale IQ of 59 or less; or

C. A valid performance, verbal or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant limitation of function; or

D. A valid performance, verbal or full scale IQ of 60 to 69 inconclusive and one of the following:

1. Marked impairment in social functioning; or

2. Marked impairment in personal/behavioral function.

112.06 Anxiety-Related Disorders: In these disorders, anxiety is either the predominant clinical feature or is experienced if the individual attempts to master symptoms; e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety, or confronting strangers or peers in avoidant disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. Excessive anxiety manifested when the child is separated; or separation is threatened, from a parent or parent surrogate; or

2. Excessive and persistent avoidance of strangers; or

3. Generalized persistent anxiety or worry; or

4. A persistent irrational fear of a specific object, activity or situation which results in compelling desire to avoid the dreaded object, activity or situation; or

5. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and instrusive recollections of traumatic experience, including dreams, which are a source of marked distress; and

B. Resulting in at least three of the appropriate age-group criteria in paragraph of 112.02.

112.07 Disorders with Physical Manifestations: Manifested by physical symptoms for which there is no demonstrable organic etiology or known physiological cause.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. A persistent and serious disturbance of eating habits, accompanied by marked and unrealistic anxiety concerning appearance resulting in weight loss, emaciation, or other serious physical sequelae; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance in one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia); or

f. Sensation (diminished or heightened); or

g. Digestion or elimination; or

4. Unrealistic interpretation of physical signs or sensations associated with the fear or belief that one has a serious disease or injury, which persists despite medical reassurance; and

B. Resulting in at least three of the appropriate age-group criteria in paragraph B of 112.02.

112.08 Personality Disorders: Evaluate under 12.08 of Part A of Appendix 1.

112.09 Autism and Other Pervasive Developmental Disorders: Autism is a pervasive disorder characterized by significant social and communication deficits originating in the developmental period. Other pervasive developmental disorders are characterized by failure to develop age-appropriate social relationships, language disorders, ritualistic and compulsive behavior and, in most cases, retardation in intellectual development. Onset of the illness is in early childhood.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autism, at least two of the following:

a. Pervasive lack of responsiveness to other people; or

b. Gross deficits in language development; or

c. Bizarre responses to various aspects of the environment (e.g., resistance to change, peculiar interest in or attachments to animate or inanimate objects); or

2. For pervasive disorders, at least three of the following:

a. Sudden excessive anxiety manifested by such symptoms as free-floating anxiety, catastrophic reactions to everyday occurrences, inability to be consoled when upset, unexplained panic attacks; or

b. Constricted or inappropriate affect, including lack of appropriate fear reactions, unexplained rage reactions, and extreme mood lability; or

c. Resistance to change in the environment (e.g., upset if dinner time is changed), or insistence on doing things in the same manner every time (e.g., putting on clothes always in the same order); or

d. Oddities of motor movement, such as peculiar posturing, peculiar hand or finger movements, or walking on tiptoe; or

e. Abnormalities of speech, such as question-like melody, monotonous voice; or

f. Hyper- or hypo-sensitivity to sensory stimuli, e.g., hyperacusis; or

g. Self-mutilation, e.g., biting or hitting self, head banging; and

B. Resulting in at least one of the appropriate age-group criteria in paragraph B of 112.02.

112.10 Developmental and Emotional Disorders of Infancy (Birth to attainment of age 1): Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

The required level of severity for these disorders is met when the requirements of A, B, C, or D are satisfied.

A. Cognitive/communicative functioning 50 percent or less of the anticipated developmental norm as documented by appropriate clinical findings (e.g., infants 0-6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing) supported, if necessary, by a standardized test; or

B. Motor development 50 percent or less of the anticipated developmental norm documented by appropriate clinical findings, supported, if necessary, by a standardized test; or

C. Apathy, over-excitability or fearfulness demonstrated by marked impairment in one of the following:

1. Response to visual stimulation; or
2. Response to auditory stimulation; or
3. Response to tactile stimulation and positioning and environment; or

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability to participate in vocal exchanges, visual exchange and motoric gestural exchanges (including facial expressions) by 6 months; or

2. Failure to communicate basic emotional state such as a wish for closeness, desire to explore objects or people, or protest or anger by 9 months; or

3. Failure to attend to the caregiver's voice or face and/or to explore an inanimate object for a period of time appropriate to the infant's age.

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